

# A threat to trans patient care quality:

gender markers, patient records, and population screening

Patients in the UK are able to change the gender marker on their NHS patient record at any time on request.<sup>1</sup> This can be undertaken without any prior contact with gender identity services, hormonal treatment or surgical intervention, or the acquisition of a Gender Recognition Certificate. Such a request triggers the creation of a novel NHS number and the importation of the patient's medical information into a new patient record.

Crucially, any reference to the patient's previous gender identity, along with their original NHS number, is irreversibly omitted from the new patient record (reversal to the original gender identity would trigger the creation of a third NHS number).

## ERADICATING MEDICALLY USEFUL INFORMATION

While this process serves to respect the patient's right to personal privacy, the eradication of such medically useful information poses a challenge to the maintenance of high-quality care for trans patients, especially in the realm of population screening programmes.

The NHS provides four adult screening programmes — for abdominal aortic aneurysm (AAA), bowel cancer, breast cancer, and cervical cancer — and invites eligible patients according to the age and gender marker recorded on their primary care patient record.

While bowel cancer screening is offered to both men and women, AAA, breast cancer, and cervical cancer screening are only offered to single genders according to their sex-specific health risks: AAA screening is offered only to men, as the risk in men is substantially higher than in women; breast cancer screening is offered only to women, as the risk in women is substantially higher than in men; and cervical cancer screening is offered only to women, as men face no risk whatsoever.

As such, patients whose primary care

patient record contains a gender marker that is incongruent with their biological sex may not be invited to the population screening programmes appropriate for their sex-specific health risks.

## HEALTH SCREENINGS

The prevalence of AAA is far higher in men aged >65 years than in women and younger men. Currently, transwomen (biological males) whose patient record gender marker is female are not routinely invited to AAA screening (but can request it), despite having the same AAA risk as men. Note: transmen (biological females) whose patient record gender marker is male are routinely invited to AAA screening, despite not having a high risk of AAA, which raises the question as to whether this is medically appropriate or if all biological females should be invited to AAA screening?

The prevalence of breast cancer is far higher in women aged >50 years than in men and younger women. Currently, transwomen whose patient record gender marker is female are routinely invited to breast screening. This is medically appropriate as transwomen who receive hormonal treatment are at substantially greater risk of breast cancer than cisgender men (biological males whose gender identity is also male).

Transwomen whose patient record gender marker is male are not routinely invited to breast screening (but can request it), despite being at increased risk of breast cancer (if they are receiving hormonal treatment).<sup>2</sup> Transmen whose patient record gender marker is male are not routinely invited to breast screening (but they can request it), despite having the same breast cancer risk as women.

Cervical cancer only affects women. Currently, transmen whose patient record gender marker is male are not routinely invited to cervical screening (but they can request it), despite having the same cervical

cancer risk as women (if they have not undergone a total hysterectomy and still retain a cervix). Note: transwomen whose patient record gender marker is female are routinely invited to cervical screening but do not undergo screening since they do not have a cervix.

The current situation as described, in which trans patient records are devoid of information pertaining to the gender assigned at birth (which is generally aligned to their biological sex), poses a risk to trans patient care quality by failing to invite patients to the population screening programmes appropriate for their sex-specific health risks.

While the well-founded ethical and legal appeals to privacy form the foundation of this situation, efforts should be made to ensure quality of care does not suffer as a consequence.<sup>3</sup>

Public health officials, in collaboration with their primary care colleagues, should take steps to respectfully communicate with trans patients their sex-specific health risks, encourage them to consider requesting and accessing the appropriate population screening programmes, and support them in doing so in a dignified manner.

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## REFERENCES

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*“The current situation ... poses a risk to trans patient care quality by failing to invite patients to the population screening programmes appropriate for their sex-specific health risks.”*